ICHS International Community HEALTH SERVICES

Advance Directives

What Are Advance Directives?

Formal Advance Directives are papers written before a serious illness that state your choices for health care (Physician Orders for Life Sustaining Treatment, also known as POLST) or name someone to make those choices (Durable Power of Attorney for Health Care), if you become unable to make decisions. Through Advance Directives, you can make legally valid decisions about your future medical care. This booklet provides information about preparing the Physician Orders for Life Sustaining Treatment and a Durable Power of Attorney for Health Care forms.

Are Advance Directives Legal?

Yes. There are federal and state laws that govern the use of Advance Directives. All 50 states and the District of Columbia have laws recognizing the use of advance directives. If you travel, you may want to take copies of your documents with you, as other states may honor these forms.

Will Advance Directives Be Recognized in Emergencies?

No. During most emergencies, there is not enough time for emergency service personnel to consult the patient's Advance Directive. Once the patient is under the direct care of a physician, there will be time for the Advance Directive to be evaluated and/or the health care agent to be consulted.

What Are Physician Orders for Life Sustaining Treatment?

The Physician Orders for Life-Sustaining Treatment (POLST) is a form that documents a physician order summarizing your wishes regarding life-sustaining treatment. The form accomplishes two major purposes:

- It is portable from one care setting to another.
- It translates wishes of an individual into actual physician orders.

The POLST form facilitates the process of translating end-of-life discussions with patients into actual treatment decisions, and provides security for the individual and physician that the expressed wishes will be carried out. There is no other form that streamlines the process in this way. A copy of the POLST is provided for you.

Can I Change My POLST?

Yes, you may change or cancel a POLST at any time. You may do this by destroying the document, putting your change in writing, or telling your doctor, nurse and family about the change. If you change your POLST, you should give new copies to your family, doctor, lawyer or others who may be involved. Your doctor must know about the change or it will not be effective.

Who Makes Health Care Decisions for Me if I Can't?

Washington state law sets the following order of priority for people to make decisions on your behalf if you cannot make decisions for yourself:

1. Your guardian, if one has been appointed
2. The person named in your Durable Power of Attorney for Health Care
3. Your spouse/registered domestic partner
4. Your adult children
5. Your parents
6. Your adult brothers and/or sisters

The person chosen to make decisions on your behalf is responsible by state law to follow your wishes as stated in your directives.

What Is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a paper in which you name another person to make medical decisions for you anytime you are unable to make them for yourself. You can include instructions about any treatment you want or do not want, such as surgery, artificial nutrition and hydration (such as fluids or medicine). You can draw up a Durable Power of Attorney for Health Care with or without the advice of a lawyer. Your representative should understand and respect your health care wishes.

Can I Change My Durable Power of Attorney for Health Care?

Yes, you may change or cancel a Durable Power of Attorney for Health Care at any time. You may do this by destroying the document, putting your change in writing, or telling your doctor, nurse and family about the change. If you change your Durable Power of Attorney for Health Care, you should give new copies to your family, doctor, lawyer, or others who may be involved.

For Further Information

These forms have been provided as a public service by the Washington State Medical Association. You are encouraged to discuss the directives with your physician. Any legal questions you may have about the use and effect of directives may be answered by an attorney.

ICHS International Community HEALTH SERVICES

International District Medical & Dental Clinic
720 8th Ave S
Seattle, WA 98104
206.788.3700

Holly Park Medical & Dental Clinic
3815 S Othello St
Seattle, WA 98118
206.788.3500

Shoreline Medical & Dental Clinic
16549 Aurora Ave N
Shoreline, WA 98133
206.533.2600

Bellevue Medical & Dental Clinic
1050 140th Ave NE
Bellevue, WA 98005
425.373.3000

ICHS Primary Care Clinic at ACRS
3639 Martin Luther King Jr Way S
Seattle, WA 98144
206.788.3700

ICHS Legacy House
803 S Lane St
Seattle, WA 98104
206.292.5184

Rev. March 2024

This form is for information only and is not an official copy of the POLST.
The official copy will be a green form signed by you and your provider.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: *See page 2 for complete instructions.*

MEDICAL CONDITIONS / INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A — Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing.

CHECK ONE

☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B — Level of Medical Interventions: When the individual has a pulse and/or is breathing.

CHECK ONE

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

C — Signatures:

A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association
Physician Driven, Patient Focused

Washington State Department of Health

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL	DATE OF BIRTH / /

Additional Contact Information (if any)

LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.
Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.
☐ Preference is to discuss medically assisted nutrition options, as indicated.*
Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: _____ Individual _____ Health Care Professional _____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

Completing POLST

- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Honoring POLST

Everyone shall be treated with dignity and respect.

SECTIONS A AND B:

- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

Reviewing POLST

This POLST should be reviewed whenever:

- The individual is transferred from one care setting or care level to another.
- There is a substantial change in the individual's health status.
- The individual's treatment preferences change.

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: <u>Use this section to update and confirm order and preferences.</u>

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided ☐ New Form Completed

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST, visit **www.wsma.org/POLST**.

ADVANCE DIRECTIVE: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This advance directive, a durable power of attorney for health care, allows you to name and prepare your health care agent. This form meets the requirements of Washington state law.

My Information:

FULL NAME: PRONOUNS (optional):

(i.e., he/she/they)

DATE OF BIRTH: / /

(mm/dd/yyyy)

NAMING A HEALTH CARE AGENT

The person I designate as my health care agent is:

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

The people I designate as my alternate agents are:

If the person listed above is unable or unwilling to make my health care decisions, then I designate the people listed below as my first and second alternate health care agents.

First Alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

Second Alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

Situations that may apply:

*Initial next to the statements below that apply to you. You may draw a line through statements that do not apply to you. For more information: see the ACP Overview, visit **www.HonoringChoicesPNW.org**, or talk with your health care provider.*

____ If I name my spouse or registered domestic partner as my health care agent and we later file for a dissolution, annulment, or legal separation; I want them to continue as my health care agent.

____ I am not naming a health care agent. By sharing my goals and values in this form, it will be considered a personal values statement and not an advance directive.

PREPARING A HEALTH CARE AGENT

What matters most to me?

This section helps you think about what matters most to you. This information can guide the people who matter to you — like your health care agent and loved ones — to make health care decisions for you if you cannot make them yourself. Consider sharing:

- What do you love to do, mentally and physically?
- How important is it for you to know who you are and who you are with?
- How important is communicating with family and friends to you?
- What does "living well" or "a good day" look like to you?
- What do you value most in your life?

The following is what matters most to me: *(Be specific. Add pages if needed.)*

What are my beliefs, preferences, and practices?

It is important for the people who matter to you—like your health care agent and loved ones—and your health care team to know about your beliefs, preferences, and practices. Consider sharing:

- What provides you support, comfort, and strength during difficult times?
- What medical treatments would you want or not want (e.g., blood transfusion, pain management, artificial feeding)?
- How are health care decisions made in your community, culture, or family?

The following beliefs, preferences, and practices are important to me: *(Be specific. Add pages if needed.)*

I would want the following person(s) contacted to support my beliefs, preferences, and practices: *(They will not have power to make health care decisions.)*

NAME: ROLE:

PHONE: ( ) ORGANIZATION:

PREPARING A HEALTH CARE AGENT

In answering the following questions, I am sharing my health care preferences. If I cannot make health care decisions for myself, I want my health care agent to use this information to guide their decisions. I understand that this information can guide my care, but it might not be possible to follow my wishes exactly in every situation.

CPR: What are my wishes?

Standard care in Washington state is to provide cardiopulmonary resuscitation (CPR) to people if their heart and breathing stop. This section can guide your health care agent and health care providers on whether to perform CPR if you are hospitalized and your heart and breathing stop (also known as "code status").

If I am hospitalized and my heart and breathing stop:

- ☐ I want CPR attempted.
- ☐ I want CPR attempted, unless there has been a change in my health, and I have:
  - Little chance of living a life that aligns with the goals and values I have stated in this form and/or discussed with my health care agent; or
  - A disease or injury that cannot be cured, and I am likely to die soon; or
  - Little chance of survival even if my heart is started again.
- ☐ I do not want CPR attempted. I want to be allowed to die naturally. *(Talk to your health care provider about a POLST form.)*

Life Support: What are my wishes?

Your response below is intended to guide your health care agent. Answering this question does not make this form a health care directive, which is a directive to withdraw or withhold life-sustaining treatment in specific situations under Washington state law. For more information, visit www.HonoringChoicesPNW.org or talk with your health care provider.

If I am so sick or injured that I am likely to die soon or am in a coma and unlikely to recover, I want my health care agent to:

- ☐ Use all life-support treatments to keep me alive even if there is little chance of recovery. I want to stay on life support.
- ☐ Try all life-support treatments that my health care providers think might help me recover. If the treatments do not work and there is little chance of living a life that aligns with my goals and values, I do not want to stay on life support. At that point, allow me to die naturally.
- ☐ Allow me to die naturally. I do not want to be on life support. If life-support treatments have been started, I want them to be stopped.
- ☐ I want my health care agent to decide for me.

Additional Directions

If I am dying and my medical care, support system, and resources allow, my preference would be to die:

- ☐ At my home or the home of a loved one (with hospice if desired).
- ☐ In a medical facility.
- ☐ I do not have a preference.
- ☐ Other (please describe): _____

If I am pregnant and cannot make health care decisions for myself, I would like my health care agent and health care providers to take the following into consideration as they make health care decisions on my behalf:

NAME: _____

DATE OF BIRTH: / / _____
(mm/dd/yyyy)

Additional Directions

Write any additional information you want your health care agent, health care providers, or others to know about your health care wishes. Please note that your wishes for organ donation and plans for your remains should be documented separately.

AUTHORIZING A HEALTH CARE AGENT

Statement of General Authority and Powers of My Health Care Agent: I authorize my health care agent to give consent for medical treatments when I cannot make my own decisions. I authorize my health care agent to carry out my wishes regarding life-support treatments such as a CPR, breathing machines, feeding tubes, blood transfusions, and kidney dialysis. This includes consent to start, continue, or stop medical treatment.

I attest to the following: I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices and my goals, values, and preferences. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE: DATE:

ADDRESS, CITY, STATE, ZIP:

Witnesses or Notary Requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

OPTION 1 – TWO WITNESSES

Witness Attestation: I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE: DATE:

NAME PRINTED:

WITNESS #2 SIGNATURE: DATE:

NAME PRINTED:

Rules for Witnesses:

- Must be at least 18 years of age and competent.
- Cannot be related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Cannot be your designated health care agent.

OPTION 2 – NOTARY

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this day of ,

by (name of individual):

Signature: Title: Exp:

NAME:

DATE OF BIRTH: / /
(mm/dd/yyyy)